STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495394	A. BUILDING _____ B. WING _____	C 03/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF BON AIR	9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 3/14/17 through 3/16/17. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 124 certified bed facility was 109 at the time of the survey. The survey sample consisted of 7 current Resident reviews (Residents #1 through #6, and #10) and 3 closed record reviews (Residents #7 through #9).	F 000		
F 247 SS=D	RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE CFR(s): 483.10(e)(6) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to notify a resident/responsible party prior to a room change for one of ten residents in the survey sample, Resident #7. The facility staff failed to provide notice of a room change (including the opportunity to see the new room and meet the new roommate) to Resident #7 and/or the resident's responsible party.	F 247	The Laurels of Bon Air wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is April 30, 2017. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance	4/30/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/31/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495394	A. BUILDING _____ B. WING _____	C 03/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF BON AIR	9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 247	Continued From page 1 The findings include: Resident #7 was admitted to the facility on 5/7/16 and discharged from the facility on 8/10/16. Resident #7's diagnoses included but were not limited to: high blood pressure, high cholesterol and stroke. Resident #7's admission MDS (minimum data set) with an ARD (assessment reference date) of 5/14/16 coded the resident's cognition as moderately impaired. A complaint was received by the Office of Licensure and Certification regarding a concern after Resident #7's room change in the facility (note- the complaint was not regarding notification of room change). Review of Resident #7's clinical record (including all interdisciplinary notes) failed to reveal documentation regarding the resident's room change. On 3/16/17 at 9:25 a.m., an interview was conducted with OSM (other staff member) #5 (a social services employee). OSM #5 stated she could not provide documentation regarding Resident #7's room change including when the room change occurred. OSM #5 was asked why Resident #7 was moved. OSM #5 stated she thought the resident was transitioning into long term care. OSM #5 stated she wasn't sure who facilitated Resident #7's room change. OSM #5 was asked about the facility process and the actions that should be taken prior to a resident's room change. OSM #5 stated typically the facility staff makes the resident/responsible party aware of the room change, notifies other staff including the admissions department, introduces the resident to the new roommate, allows the resident	F 247	with regulatory requirements. F247 This resident has already been discharged from the facility. All guests have the potential to be affected. Social Services staff will audit each other□s room change notifications to ensure compliance 3 times per week for 2 weeks. Any variances from the audits will be corrected. Social Services staff will be in-serviced by the Administrator on the importance of notifying residents and/or responsible party prior to a room change. Administrator or designee will audit clinical records when room changes occur to ensure proper notification is completed 3 times per week for 2 weeks, then once per week for 2 weeks. Variances in room change notifications will be reported by the Social Services Director to QA committee for trending and analys	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495394	A. BUILDING _____ B. WING _____	C 03/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF BON AIR	9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 247	Continued From page 2	F 247		

an opportunity to see the new room and completes a room change form. OSM #5 stated she could not find a room change form regarding Resident #7's room change or provide documentation to evidence Resident #7 (or the resident's responsible party) was notified of the room change, shown the new room or introduced to the new roommate.

On 3/16/17 at 11:00 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional quality assurance manager) were made aware of the above concern. ASM #2 confirmed Resident #7 was admitted to the facility on the first floor and was transferred to the second floor during her stay. ASM #1 and ASM #2 stated they could not remember the particular details regarding the room change. ASM #1, ASM #2 and ASM #3 were asked to provide a policy regarding room changes.

On 3/16/17 at 12:10 p.m., ASM #1 provided a policy titled, "Notification of Room Change and/or Roommates" revised in November 2016, that documented, "It is the policy of this facility to notify guests and/or legal representatives in writing regarding room transfers, and the room's occupant that they will be receiving a new roommate..." ASM #1 stated the new policy was applicable since November 2016 (after Resident #7's stay in the facility) and the staff was trying to find the policy that was applicable during Resident #7's stay. On 3/16/17 at 12:15 p.m., ASM #3 stated the staff could not find the room change policy that was applicable prior to November 2016.

No further information was presented prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495394	A. BUILDING _____ B. WING _____	C 03/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF BON AIR	9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that facility staff failed to serve and prepare food in a sanitary manner. The facility staff failed to appropriately wear a hair net while in the kitchen during the lunch tray line service on 3/15/17. The findings include:	F 371	F 371 The Dietary Manager has replaced her hair net with a larger one. All guests have the potential to be affected. Dietary Manager or designee will assure that dietary staff have their hair fully covered within a hair net while in the kitchen. Any variances will be corrected	4/30/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495394	A. BUILDING _____ B. WING _____	C 03/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF BON AIR	9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 4 On 3/15/17 at 12:05 p.m., temperatures of lunch items were conducted. OSM (other staff member) # 4, the dietary manager was observed wearing her hair net with thick strands of hair coming out of the front. The front of her hair was not contained by the hair net. OSM #4 was observed standing near tray line. On 3/15/17 at 12:21 p.m. an interview was conducted with OSM #4. When asked how hair nets should be worn in the kitchen, OSM #4 stated, "The hair should be covered. Men should have their facial hair covered but men can wear hats or a hair net." OSM #4 stated that hair nets should be worn "everywhere in the kitchen." When asked if she was wearing her hair net was appropriately, OSM#4 stated, "My hair always falls out. I try to put it back 2-3 times a day. It shouldn't be hanging out if you are in the kitchen." When asked why hair nets should be worn appropriately, OSM #4 stated that hair nets should be worn correctly to prevent hair from getting into the food. On 3/16/17 at 11:00 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the corporate nurse were made aware of the above concerns. The facility policy titled, "Hair Restraints" documents in part, the following: "Policy: Hair shall be restrained to prevent physical contamination of food. Procedure: 1. Hair restraints shall be worn by all dietary employees while on duty to cover all hair. 2. The following are acceptable as hair restraints: Hairnets, scrub	F 371	immediately. Dietary staff members will be in-serviced by the Dietary Manager on company policy to ensure that 100% of their hair is covered by a hair net while in the kitchen. Administrator or designee will conduct unannounced visits to the kitchen to check to make sure hair nets are in use covering 100% of hair 3 times per week for 2 weeks then once per week for 2 weeks. Any variances identified will be corrected and additional education provided. Variances in the full coverage of hair will be reported to QA committee by the Dietary Manager for trending and analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495394	A. BUILDING _____ B. WING _____	C 03/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF BON AIR	9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 5 caps, white paper hats (If hair less than 1") Hats (if cover all hair), beard restraint. 3. Men with hair which cannot be effectively restrained (e.g. long or bushy hair) by paper caps, shall wear a hairnet or scrub cap. 4. Facial hair may be restrained by waxing. 4. (sic) Employees with hair that cannot be covered with a single hair net shall wear two (One for the front and one for the back) or a scrub cap. All hair must be kept covered (including bangs, ponytails, and beards). 5. This applies to all staff entering the kitchen including maintenance and administration. 6. Failure to wear appropriate hair restraint will result in disciplinary action. 7. This shall not apply to dietary employees such as hostess and wait staff if they present a minimal risk of contaminating exposed food or clean equipment, utensils or linens." No other documentation was presented prior to exit.	F 371		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 514		4/30/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495394	A. BUILDING _____ B. WING _____	C 03/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF BON AIR	9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 6 (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain an accurate clinical record for one of ten residents in the survey sample, Resident #7. The facility staff failed to accurately document Resident #7's diet recommendations on the resident's post-discharge care plan. The findings include: Resident #7 was admitted to the facility on 5/7/16 and discharged from the facility on 8/10/16. Resident #7's diagnoses included but were not limited to: high blood pressure, high cholesterol	F 514	F514 Resident # 7 was discharged from the facility and had no negative outcomes from this practice. All discharged residents have the potential to be affected. The DON or designee will in-service all licensed nurses on a two nurse verification of all orders transcribed on the post discharge summary for accuracy. The DON or designee will conduct audits of all discharge residents 3 times per week for 4 weeks to verify compliance. Any variances will be corrected and additional education will be provided.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495394	A. BUILDING _____ B. WING _____	C 03/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF BON AIR	9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 7	F 514	DON will report any variances identified through the audits to quality assurance committee for continued compliance.	

and stroke. Resident #7's admission MDS (minimum data set) with an ARD (assessment reference date) of 5/14/16 coded the resident's cognition as moderately impaired.

Review of Resident #7's clinical record revealed a physician's telephone order dated 8/8/16 that documented, "D/C (Discontinue) current diet. Change to Regular consistency (with) thin liquids. Cardiac. No added salt." No further diet orders were written between 8/8/16 and 8/10/16.

Resident #7's post-discharge care plan signed by LPN (licensed practical nurse) #5 and the resident's representative on 8/10/16 documented, "Diet /Recommendations: Regular diet thin liquids Soy milk..."

LPN #5 was not available for interview.

On 3/15/17 at 5:00 p.m., an interview was conducted with LPN #3. LPN #3 was asked to review Resident #7's physician's orders regarding the resident's diet. LPN #3 was asked what diet should have been documented on the resident's post-discharge care plan. LPN #3 stated if she was completing the discharge care plan then she would have documented a cardiac diet with no added salt and thin liquids.

On 3/16/17 at 8:05 a.m., an interview was conducted with RN (registered nurse) #1 (the assistant director of nursing). RN #1 confirmed post-discharge care plans were part of residents' clinical records.

On 3/16/17 at 11:00 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495394	A. BUILDING _____ B. WING _____	C 03/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF BON AIR	9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 8 quality assurance manager) were made aware of the above findings. The facility policy titled, "CONTENT OF THE CLINICAL RECORD" documented, "A separate clinical record is maintained for each guest in accordance with accepted professional standards and practices. Records are complete, accurately documented, readily accessible, and systematically organized. At a minimum, each record shall contain the following categories of data...DISCHARGE PLANNING: A summary of medications and post-care instructions is given at the time of discharge to guest and/or responsible party..." No further information was presented prior to exit.	F 514		